

APPENDIX D-1**TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION
FORM HFS 2360, HEALTH INSURANCE CLAIM FORM**

Please follow these guidelines in the preparation of claims for imaging processing to assure the most efficient processing by the Department:

- Use original department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the form.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, which is the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

These instructions follow in the order entries appear on the form and address only those fields required by the Department. A sample Health Insurance Claim Form may be found on the Department's Web site <http://www.hfs.illinois.gov/medicalforms/>

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required = Entry always required.

Optional = Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.

Conditionally Required = Entries which are required only under certain circumstances. Conditions of the requirement are identified in the instruction text.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

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| Required | 1. Recipient Name - Enter the patient's name exactly as it appears on the Identification Card or Notice issued by the Department. Separate the components of the name (first, middle initial, last) in the proper order of the name field. |
| Optional | 2. Birth date - Enter the month, day and year of birth of the patient as shown on the Identification Card or Notice issued by the Department. Use the MMDDYY format. If the birthdate is entered, the Department will, where possible, correct claims suspended due to recipient name or number errors. If the birthdate is not entered, the Department will not attempt corrections. |
| Required | 8. Recipient No. - Enter the nine-digit number assigned to the individual as shown on the Identification Card or Notice issued by the Department. Use no punctuation or spaces. Do not use the Case Identification Number. |

- Conditionally Required** **19. Referring Practitioner Name** - Enter the name of the physician who requested services to be provided. This entry is required when charges are being submitted for a consultation.
- Referring Physican Number** - The referring physician number is always required when a referring practitioner name is entered. Enter the state license number, Social Security number or AMA number of the physician who requested services to be provided.
- Conditionally Required** **21. Facility & City Where Service Rendered** - This entry is required when Place of Service Code in Field 24B is other than office.
- Conditionally Required** **23a. Healthy Kids** - If a provider completed a Healthy Kids screening or if diagnostic and/or treatment services were rendered as a result of a referral from a Healthy Kids (EPSDT) screening, enter an "X" in the Yes box.
- Conditionally Required** **23b. Family Planning** - If services were rendered for family planning purposes, enter an "X" in the Yes box.
- Required** **23e. Type of Service** - Enter the code corresponding to the procedure for which charges are submitted.
- Only one type of service can be included on a single invoice. A separate invoice must be prepared for each type of service for which charges are made.
- The following Type of Service codes are to be used:
- 1 Medical Care - Attending Physician
 - 2 Surgery - Surgeon
 - 3 Consultation - Consultant
- Required** **24a. Date of Service** - Enter the date the service was performed (one date of service per document). Use the MMDDYY format.
- Required** **24b. Place of Service** - Use the Place of Service code appropriate for the particular service. These Place of Service codes may be obtained from http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf

Required	<p>24c. Procedure Code/Drug Item Number - Enter the appropriate encounter procedure code in Service Section 1 of the claim.</p> <p>In Service Sections 2 through 7 of the claim, enter the appropriate CPT, NDC or HCPCS procedure codes for the services rendered during the encounter. Detail lines are mandatory. If more than one claim is required to identify detail services, Service Section 1 of the additional claims must always contain the encounter code.</p>
Conditionally Required	<p>MOD - Enter the appropriate two-byte modifier(s) for the service performed. This entry is required when the encounter billed is for behavioral health, family planning or EPSDT.</p>
Required	<p>24d. Primary Diagnosis - Enter the specific ICD 9-CM code without the decimal for the primary diagnosis.</p> <p>Secondary Diagnosis - An entry in this field is optional. A second ICD-9-CM code may be entered to identify a secondary diagnosis when appropriate.</p>
Required	<p>24e. Provider Charge - Enter the clinic's unique encounter rate in Service Section 1. In Service Sections 2 through 7, enter either 0.00 or the clinic's usual and customary charges.</p>
Conditionally Required	<p>24f. Days/Units - Enter the appropriate number of units in the detail service sections. For the department's quantity limitations, refer to the physician's fee schedule on the Web site at http://www.hfs.illinois.gov/feeschedule/</p>
Conditionally Required	<p>Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire service section. Only "X" will be recognized as a valid character; all others will be ignored.</p>
Required	<p>25. Signature of Physician and Date Signed - After reading the certification statement, the provider or their designee must sign the completed form. The signature date is to be entered in MMDDYY format. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable.</p>
Required	<p>27. Total Charge - Enter the sum of all charges shown in Service Sections 1 through 7.</p>

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|-----------------|---|
| Required | 28. Amount Paid - Enter the total of all payments received from other sources. If no payment was received enter 0 00. |
| Required | 29. Balance Due - Enter the difference between the total charge and amount paid. |
| Required | 30. Provider Number - Enter the 12-digit Provider Number exactly as it appears on the Provider Information Sheet. |
| Required | 31. Physician's or Supplier's Name, Address, ZIP Code - Enter the clinic's name exactly as it is shown on the Provider Information Sheet. |
| Optional | 32. Your Patient's Account Number - Enter up to 20 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form HFS 194-M-1, Remittance Advice, returned to the provider. |
| Required | 33. Payee - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |
| Required | 34. Number of Sections - Enter the total number of service sections in Item 24 which have been correctly completed. |

**Conditionally
Required**

37A. TPL Code - If the patient's Identification Card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the Chapter 100, General Appendix 9. If none of the TPL codes in General Appendix 9 are applicable to the source of payment, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Section 38.

Spenddown - Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. The following provides examples.

When the date of service is the same as the "Spenddown Met" date on the HFS 2432 (Split Billing Transmittal) attach the HFS 2432 to the claim form. The split bill transmittal supplies the information necessary to complete the TPL fields.

If Form HFS 2432 shows a recipient liability greater than \$0.00 the service section should be coded as follows:

TPL Code	906
TPL Status	01
TPL Amount	The actual recipient liability as shown on HFS Form 2432.
TPL Date	The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

If Form HFS 2432 shows a recipient liability of \$0.00 the service section should be coded as follows:

TPL Code	906
TPL Status	04
TPL Amount	0 00
TPL Date	The issue date on the bottom right corner of the HFS 2432. This is in MMDDYY format.

**Conditionally
Required**

37B. Status - If a TPL code is shown in the previous item, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code is blank.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown - TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered - TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered - TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met - TPL status code 04 is to be entered when the patient's Form HFS 2432 shows \$0.00 liability.

05 - Patient not covered - TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the Identification Card is not in force.

06 - Services not covered - TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending - TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met - TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

37C. TPL Amount - Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" box. For all other Status Codes, enter 0 00. If there is no TPL code, no entry is required.

Conditionally Required **37D. TPL Date** - A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Status

Code

Date to be entered

01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432, Split Billing Transmittal
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Conditionally Required **38A. TPL Code** - (See 37A above).

Conditionally Required **38B. Status** - (See 37B above).

Conditionally Required **38C. TPL Amount** - (See 37C above).

Conditionally Required **38D. TPL Date** - (See 37D above).

MAILING INSTRUCTIONS

The Health Insurance Claim Form is a single page or two-part form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The copy of the claim should be retained by the provider.

Routine claims are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 1444, Provider Invoice Envelope, provided by the Department.

Mailing address: Healthcare and Family Services
 P.O. Box 19105
 Springfield, Illinois 62794-9105

Non-routine claims (claims with attachments, such as EOB or HFS 2432, Split Billing Transmittal) are to be mailed to the Department in pre-addressed mailing envelope, Form HFS 1414, Special Approval Envelope, which is provided by the Department for this purpose.

Mailing address: Healthcare and Family Services
 P.O. Box 19118
 Springfield, Illinois 62794-9118

Forms Requisition

Billing forms may be requested on our Web site at <http://www.hfs.illinois.gov/forms/> or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

APPENDIX D-1a
TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION
FORM HFS 3797, MEDICARE CROSSOVER INVOICE

To assure the most efficient processing by the Department, please follow these guidelines in the preparation of claims for imaging processing:

- Use original Department issued claim form.
- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the form.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed characters per inch, which is the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as a part of the original or as a result of photo-copying a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims. Do not fold invoices or fasten attachments with staples.

Instructions for completion of this invoice follow in the order that entries appear on the form. Mailing instructions follow the claim preparation instructions. A sample Medicare Crossover Invoice may be found on the Department's Web site

<http://www.hfs.illinois.gov/medicalforms/>

If billing for a Medicare denied or disallowed service, bill on the appropriate HFS Medicaid form.

Identification Card – the card issued monthly by the Department to each person or family who is eligible under Medical Assistance, Transitional Assistance (City of Chicago), State Family and Children Assistance (City of Chicago) All Kids Assist, All Kids Moms and Babies, or All Kids Level 1-8 and for Qualified Medicare Beneficiary (QMB) who is not eligible for Medical Assistance, but is eligible for Department consideration of Medicare coinsurance and deductibles.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude corrections of certain claiming errors by the Department.
Conditionally Required	=	Entries that are required based on certain circumstances. Conditions of the requirement are identified in the instruction text.

COMPLETION

ITEM EXPLANATION AND INSTRUCTIONS

Required

Claim Type - Enter a capital "X" in the appropriate box using the following guideline when determining claim type:

23 - Practitioner - physicians, optometrists, podiatrists, therapists, audiologists, hospitals (fee-for-service), RHC, FQHC, Imaging Centers

24 - Dental - dental providers

25 - Lab/Port X-Ray - all laboratories

26 - Med. Equip/Supply - medical equipment and supply providers, pharmacies

28 - Transportation - ambulance service providers (previously billed on HCFA 1491)

If provider type is not indicated above, enter a capital "X" in the Practitioner box.

Required

- 1. Recipient's Name** - Enter the recipient's name (first, middle, last) exactly as it appears on the back of the Identification Card.

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| Required | 2. | Recipient's Birth date - Enter the month, day and year of birth. Use the MMDDYY format. |
| Required | 3. | Recipient's Sex - Enter a capital "X" in the appropriate box. |
| Conditionally Required | 4. | Was Condition Related to -
A. Recipient's Employment - Treatment for an injury or illness that resulted from recipient's employment enter a capital "X" in the "Yes" box.
B. Accident - Injury or a condition that resulted from an accident, enter a capital "X" in Field B, Auto or Other as appropriate.

Any item marked "Yes" indicates there may be other insurance primary to Medicare. Identify primary insurance in Field 9. |
| Required | 5. | Recipient's Medicaid Number - Enter the individual's assigned nine-digit number from the Identification Card. Do not use the Case identification Number. |
| Required | 6. | Medicare HIC (Health Insurance Claim) Number - Enter the Medicare Health Insurance Claim Number (HICN). |
| Required | 7. | Recipient's Relation to Insured - Enter a capital "X" in the appropriate box. |
| Required | 8. | Recipient's or Authorized Person's Signature - The recipient or authorized representative must sign and enter a date unless the signature is on file with the provider/supplier. If the signature is on file, enter the statement "Signature on File" here. |
| Conditionally Required | 9. | Other Health Insurance Information - If the recipient has an additional health benefit plan, enter a capital "X" in the "YES" box. Enter Insured's name, Insurance Plan/Program Name and Policy/Group No., as appropriate. |
| Required | 10A. | Date(s) of Service - The "From" date is the only date necessary to complete. Use the MMDDYY format. |
| Required | 10B. | P.O.S. (Place of Service) - Use the Place of Service code appropriate for the particular service. These Place of Service codes may be obtained from
http://www.cms.hhs.gov/MedHCPCSGenInfo/Downloads/Place_of_Service.pdf |

- Required** **10C. T.O.S. (Type of Service)** - Enter the code corresponding to the procedure for which charges are submitted.
- Only one type of service can be included on a single invoice. A separate invoice must be prepared for each type of service for which charges are made.
- The following Type of Service codes are to be used:
- 1 Medical Care - Attending Physician
 - 2 Surgery - Surgeon
 - 3 Consultation - Consultant
- Required** **10D. Days or Units** - Enter the number of services (NOS) shown on the Explanation of Medicare Benefits (EOMB). All entries must be four digits, i.e., 0001.
- Mileage - Enter the total number of miles as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 32 miles is 0032.
- Anesthesia or Assistant Surgery Services - Enter the total number of units as shown on the Explanation of Medicare Benefits (EOMB). All entries must be in a four-digit format; the entry for 1 unit is 0001.
- Required** **10E. Procedure Code** - Procedure code T1015 is the only procedure code that should be billed. **No detail coding is to be reported, including NDCs and HCPCS codes.**
- Required** **10F. Amount Allowed** - Identify the "per diem rate" as shown on the Explanation of Medicare Benefits (EOMB).
- Required** **10G. Deductible** - Identify the dollar amount applied to the patient's deductible as shown on the Explanation of Medicare Benefits (EOMB).
- Required** **10H. Coinsurance** - Identify the dollar amount designated as the patient's coinsurance as shown on the Explanation of Medicare Benefits (EOMB).
- Required** **10I. Provider Paid** - Identify the net reimbursement as shown on the Explanation of Medicare Benefits (EOMB).

Not Required	11.	For NDC Use Only - Required when billing NDC codes for pharmacy/physician claims. If an NDC code has been billed to Medicare, pharmacies and physicians are to complete all service information in Section 10, (excluding 10E) and complete the corresponding Service Section in Field 11 with the NDC that was billed to Medicare.
Conditionally Required	12.	For Modifier Use Only - Enter HCPCS or CPT modifiers for the procedure code entered in Field 10E, as applicable.
Not Required	13A.	Origin of Service - Enter the facility name or origin place address and city from where the patient was transported.
Not Required	13B.	Modifier - Enter the first alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	14A.	Destination of Service - Enter the facility name or destination place address and city from where the patient was transported.
Not Required	14B.	Modifier - Enter the second alpha character located immediately after the procedure code as shown on the Explanation of Medicare Benefits (EOMB).
Not Required	15A.	Origin of Service - Leave blank.
Not Required	15B.	Modifier - Leave blank.
Not Required	16A.	Destination of Service - Leave blank.
Not Required	16B.	Modifier - Leave blank.
Required	17.	ICN # - Enter the Medicare Invoice Control Number.
Conditionally Required	18.	Diagnosis or Nature of Injury or Illness - Enter the description of the diagnosis or nature of injury or illness that describes the condition primarily responsible for the recipient's treatments. A written description is not required if a valid ICD-9-CM code is entered in Field 18A.
Required	18A.	Primary Diagnosis Code - Enter the valid ICD-9-CM diagnosis code for the services rendered.
Optional	18B.	Secondary Diagnosis Code - A secondary diagnosis may be entered if applicable. Enter only a valid ICD-9-CM diagnosis code.

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| Required | 19. Medicare Payment Date - Enter the date Medicare made payment. This date is located on the Explanation of Medicare Benefits (EOMB). |
| Conditionally Required | 20. Name and Address of Facility Where Services Rendered
This entry is required when Place of Service (10B) is other than provider's office or recipient's home. Enter the facility name and address where the service(s) was furnished. When the name and address of the facility where the services were furnished is the same as the biller's name and address as submitted in Field 22, enter the word "Same." |
| Required | 21. Accept Assignment - The provider must accept assignment of Medicare benefits for services provided to recipients for the Department to consider payment of deductible and coinsurance amounts. Enter a capital "X" in the "Yes" box if accepting assignment. |
| Required | 22. Physician/Supplier Name, Address, City, State, ZIP Code
Enter the physician/supplier name exactly as it appears on the Provider Information Sheet under "Provider Key." |
| Required | 23. HFS Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet. |
| Required | 24. Payee Code - Enter the single digit number |
| Conditionally Required | 25. Name of Referring Physician or Facility - Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.

Referring Physician - a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare Program.

Ordering Physician - a physician who orders non-physician services for the patient such as diagnostic tests, clinical laboratory tests, pharmaceutical services or durable medical equipment. |
| Conditionally Required | 26. Identification Number of Referring Physician - This item is required if Field 25 has been completed (Name of Referring Physician or Facility). All claims for Medicare covered services and items that are a result of a physician's order or referral must include the ordering/referring physician's Unique Physician/Practitioner Identification Number (UPIN). |

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| Required | 27. Medicare Provider ID Number (PIN) - Identify the six-digit PIN for the FQHC or RHC. |
| Required | 28. Taxonomy Code - Enter the appropriate ten-digit HIPAA Provider Taxonomy code. Refer to Chapter 300, Appendix 5. |
| Conditionally Required | 29A. TPL Code - If the patient's Identification Card contains a TPL code, the numeric three-digit code must be entered in this field. If payment was received from a third party resource not listed on the patient's card, enter the appropriate TPL Code as listed in the Chapter 100, General Appendix 9. If none of the TPL codes in General Appendix 9 are applicable to the source of payment, enter code "999." If more than one third party made a payment for a particular service, the additional payment is to be shown in Fields 30A-30D. |

**Conditionally
Required**

29B. Status - If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown - TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received **must** be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered - TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered - TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met - TPL status code 04 is to be entered when the patient's Form HFS 2432 shows \$0.00 liability.

05 - Patient not covered - TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the Identification Card is not in force.

06 - Services not covered - TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending - TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

10 - Deductible not met - TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

29C. TPL Amount - Enter the amount of payment received from the patient's third party for the service. A dollar amount entry is required if TPL Status Code 01 was entered in the "Status" field.

Conditionally Required **29D. TPL Date** - A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Status

Code

Date to be entered

01	Third Party Adjudication Date
02	Third Party Adjudication Date
03	Third Party Adjudication Date
04	Date from the HFS 2432, Split Billing Transmittal
05	Date of Service
06	Date of Service
07	Date of Service
10	Third Party Adjudication Date

Conditionally Required **30A. TPL Code** - (See 29A above).

Conditionally Required **30B. TPL Status** - (See 29B above).

Conditionally Required **30C. TPL Amount** - (See 29C above).

Conditionally Required **30D. TPL Date** - (See 29D above).

Required **31. Provider Signature** - After reading the certification statement printed on the back of the claim form, the provider or authorized representative must sign the completed form. The signature must be handwritten in black ink. A stamped or facsimile signature is not acceptable. Unsigned claims will not be accepted by the Department and will be returned to the provider. The provider's signature should not enter the date section of this field.

Required **32. Date** - The date of the provider's signature is to be entered in the MMDDYY format.

MAILING INSTRUCTIONS

The Medicare Crossover Invoice is a single page or two-part continuous feed form. The provider is to submit the original of the form to the Department as indicated below. The pin-feed guide strip of the two-part continuous feed form should be removed prior to submission to the Department. The yellow copy of the claim should be retained by the provider.

Invoices are to be mailed to the Department in pre-addressed mailing envelopes, Form HFS 824MCR, Medicare Crossover Invoice Envelope, provided by the Department.

Mailing address: Medicare Crossover Invoice
Healthcare and Family Services
P.O. Box 19109
Springfield, Illinois 62794-9109

Do not bend or fold claims prior to submission.

Forms Requisition

Billing forms may be requested on our Web site at <http://www.hfs.illinois.gov/forms/> or by submitting a HFS 1517 as explained in Chapter 100, General Appendix 10.

APPENDIX D-2

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. (See Topic D-201.4 for instructions.) If all the information noted on the sheet is correct, the provider is to keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix D-2a. The item or area numbers that correspond to the explanations below appear in small circles ○ on the sample form.

FIELD	EXPLANATION
① PROVIDER KEY	This number uniquely identifies the provider and is to be used as the provider number when billing charges to the Department.
② PROVIDER NAME AND LOCATION	This area contains the NAME AND ADDRESS of the provider as carried in the Department's records. The three- digit COUNTY code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The TELEPHONE NUMBER is the primary telephone number of the provider's primary office.
③ ENROLLMENT SPECIFICS	<p>This area contains basic information reflecting the manner in which the provider is enrolled with the Department.</p> <p>PROVIDER TYPE is a three-digit code and corresponding narrative which indicates the provider's classification.</p>

ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which the provider primarily performs services. The possible codes are:

01 = Individual Practice

02 = Partnership

03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active

I = Inactive

N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in the Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Exception Requested By Audits

C = Citation to Discover Assets

G = Garnishment

S = Exception Requested By Provider
Participation Unit

T = Tax Levy

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form HFS 1413, Provider Agreement, on file and the provider is

eligible to submit claims electronically. Possible entries are YES or NO.

4

**CERTIFICATION/
LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5

S.S.#

This is the provider's Social Security or FEIN number.

6

**SPECIALTY AND
CATEGORIES
OF SERVICE**

This area identifies special licensure information and the types of services a provider is enrolled to provide.

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

026	Clinic Services
030	Healthy Kids Services
058	Social Worker
059	Psychologist

Each entry is followed by the date that the provider was approved to render services for each category listed.

7

**PAYEE
INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single digit **PAYEE CODE**, which is to be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes, therefore no payments can be made to a payee unless the number is on file. Immediately following this number is the effective date when payment may be made to each payee on behalf of the provider.

8

SIGNATURE

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

The provider is required to affix an original signature when submitting changes to the Department.

APPENDIX D-2a

Reduced Facsimile of Provider Information Sheet

<p>1</p> <p>MEDICAID SYSTEM (MMIS) PROVIDER SUBSYSTEM REPORT ID: A2741KD1 SEQUENCE: PROVIDER TYPE PROVIDER NAME</p>	<p>2</p> <p>STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES PROVIDER INFORMATION SHEET</p>	<p>3</p> <p>RUN DATE: 05/01/06 RUN TIME: 11:47:06 MAINT DATE: 08/02/06 PAGE: 84</p>																								
<p>1</p> <p>--PROVIDER KEY-- 33333333001</p>	<p>PROVIDER NAME AND ADDRESS ABC Clinic 1441 MY STREET ANYTOWN, IL 62222-2222</p> <p>PROVIDER GENDER: COUNTY 200 - COOK TELEPHONE NUMBER: (888)123-4567 D.E.A. #: RE-ENROLLMENT INDICATOR: N</p>	<p>PROVIDER TYPE: 040 - FQHC ORGANIZATION TYPE: 02 - CORP PRACT ENROLLMENT STATUS B - ACTIV NOCST BEGIN 05/01/2006 END ACTIVE EXCEPTION INDICATOR - NO EXCEPT BEGIN END CERTIFIC/LICENSE NUM - 4 ENDING 03/31/02 LAST TRANSACTION COR AS OF 05/01/06 MEDICARE # S.S. #: 331313131 CLIA #:</p>																								
<p>6</p> <table border="0" style="width: 100%;"> <tr> <th style="text-align: left;">CODE</th> <th style="text-align: left;">PROCEDURE DESCRIPTION</th> <th style="text-align: left;">BEGIN</th> <th style="text-align: left;">CURRENT RATE</th> </tr> <tr> <td>T1015</td> <td>CLINIC VISIT/ENCOUNTER</td> <td>05/01/06</td> <td>\$100.00</td> </tr> <tr> <td>ELIG</td> <td></td> <td></td> <td>ELIG</td> </tr> <tr> <th style="text-align: left;">COS</th> <th style="text-align: left;">ELIGIBILITY CATEGORY OF SERVICE</th> <th style="text-align: left;">BEG DATE</th> <th style="text-align: left;">COS</th> </tr> <tr> <td>026</td> <td>Clinic Services</td> <td>05/01/06</td> <td></td> </tr> <tr> <td>030</td> <td>Healthy Kids Services</td> <td>05/01/06</td> <td></td> </tr> </table>			CODE	PROCEDURE DESCRIPTION	BEGIN	CURRENT RATE	T1015	CLINIC VISIT/ENCOUNTER	05/01/06	\$100.00	ELIG			ELIG	COS	ELIGIBILITY CATEGORY OF SERVICE	BEG DATE	COS	026	Clinic Services	05/01/06		030	Healthy Kids Services	05/01/06	
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